APPLICANT NAME (Please Print) _____

MEDICAL EYE EXAM FOR COMBATIVE SPORTS

Exam with dilation must be done by an OPTHALMOLOGIST or OPTOMETRIST

Examination (normal-N; abnormal –X)	RIGHT EYE	LEFT EYE
VISUAL ACUITY (WITHOUT CORRECTION)	N_____ F_____	N_____ F_____
EXTERIOR EXAM	_____	_____
ANTERIOR EXAM	_____	_____
FUNDI	_____	_____
EXTRACOCULAR MUSCLES	_____	_____
VISUAL FIELDS (Confrontation)	_____	_____
TONOMETRY	_____	_____

EXPLAIN ABNORMAL FINDINGS

DIAGNOSIS_____
_____
_____
_____

I hereby certify that a dilated exam was performed on:_____
(please print applicant's name)

Date of the exam: _____ , _____ _____
Month   Day   Year

I HAVE APPROVED THIS PERSON TO PARTICIPATE IN A COMBATIVE SPORTS EVENT.

Ophthalmologist or Optometrist NAME _____
(please print)

LICENSE # _____
(must be licensed in a State, District or Territory of the United States)

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE NUMBER _____

OPHTHAMOLOGIST or
OPTOMETRIST SIGNATURE _____ DATE _____

APPLICANT SIGNATURE _____ **DATE**
_____

APPLICANT AFFIDAVIT:
I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the